No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28515

FILED SEP 7 1948

Registration District No. 947

Primary Registration District No. 6976

Registrar's No. 1978

1. PLACE OF DEATH:

(a) County St, Louis

(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Telegraph and Baumgartner Roads 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 da (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 100

(c) City or town Fornfelt
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charles Wm Owens

3. (b) If veteran, name war no

3. (c) Social Security No. unknown

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife nil

6. (c) Age of husband or wife if alive nil years

7. Birth date of deceased Jan 7 1930
(Month) (Day) (Year)

8. AGE: Years 18 Months 7 Days 13 If less than one day hr. min.

9. Birthplace Ancell Mo
(City, town, or county) (State or foreign country)

10. Usual occupation River Worker

11. Industry or business

FATHER
12. Name Wm Ownes
13. Birthplace Louisville, Mo
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Alma Coomer
15. Birthplace Randles, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Wm R. Ownes
(b) Address Fornfelt, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23/48
(Month) (Day) (Year)
(c) Place: burial or cremation Illmo. Mo

18. (a) Signature of funeral director Rowland Mortuary Service
(b) Address 4104 Manchester Ave.

19. (a) 8/22-48 (Date received local registrar) (b) Cecil A. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20
year 1948 hour 3 minute 40 P M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Unknown	
Due to 200 C	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Cecil A. Sharp (M. D. ~~or other~~)

Address Commissioner of Health Date signed 8-26-48

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....J. Allen Davis Jr.....

Licensed Embalmer No.....4053.....

P. O. Address.....St. Louis.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.